Andy Slavitt, Acting Administrator, CMS
"Implementation of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)"
Before the
Committee on Ways & Means, Subcommittee on Health

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Additional Questions for the Record

From Representative George Holding of North Carolina:

As you know, the MACRA statute provides for bonus payments to health professionals who participate in certain Alternative Payment Models (APMs), which MACRA refers to as "eligible" APMs.

To be "eligible," (1) health professionals in the APM must use Certified Electronic-Health-Records (EHR) Technology; (2) the APM must make payments to the health professionals on the basis of Quality Measures; and (3) the APM must bear financial risk for monetary losses that are in excess of a nominal amount.

I note that, in the MACRA proposed rule, CMS has expressly decided that a particular type of APM—the Bundled Payment for Care Improvement (BPCI) Model—is not an eligible APM.

The BPCI APM Model was developed by the Center for Medicare and Medicaid Innovation (CMMI). In this type of APM, payments are linked to patients' particular episodes of care, and the APM is responsible for financial losses. The goal is to provide higher quality and more coordinated care at a lower cost to Medicare.

The BPCI APM Model has been successful.

1. **What is the logical and legal basis for CMS to decide that the BPCI APM Model is not an eligible APM? This type of APM bears the financial risk of monetary losses; it participates in all applicable CMS Quality Measures; and the majority of its health professionals use Certified EHR Technology.**

2. **Why did the agency decide not to use the statutory term "eligible" APM but to instead create the term "Advanced" APM for use in the MACRA proposed rule?**

Answer: In the proposed rule, we have proposed the term "Advanced APM" for those APMs defined by section 1833(z)(3)(C) of the Act that meet the criteria under section 1833(z)(3)(D) of the Act. The statute indirectly defines the term "eligible APM" as the APMs in which "eligible alternative payment entities" participate. We decided to use the term "Advanced" in lieu of "Eligible" for those APMs meeting the criteria under section 1833(z)(3)(D) of the Act. Rather

than referring indirectly to the APM in which an eligible alternative payment entity participates, we believe it is essential to the understanding of the proposed rule to be able to identify and propose requirements directly for an Advanced APM.

3. **Does the decision to refer to "Advanced" APMs and to exclude a worthy APM such as the BPCI APM Model demonstrate that CMS has moved the bar beyond the parameters of the MACRA statute?**

Answer to 1 & 3: To qualify as an Advanced APM, we proposed that an APM must meet three criteria specified in the statute. The APM must:

- Require participants to use certified EHR technology
- Provide for payment for covered professional services based on quality measures comparable to those in the quality performance category under MIPS
- Require that participating APM entities bear risk for monetary losses of more than a nominal amount or be a Medical Home Model expanded under CMMI authority.

While the BPCI Models 2, 3, and 4 would meet the proposed financial risk criterion for Advanced APMs, they do not require participants to use certified electronic health record technology or incorporate quality measure results as a factor when determining payment to participants, as required by statutory criteria. In addition, in our proposed rule, we specifically sought feedback on how we might change the design of the Comprehensive Care for Joint Replacement (CJR) model through future rulemaking to make it an Advanced APM, and on how to include eligible clinicians in CJR as qualifying participants of Advanced APMs. We look forward to receiving and reviewing comments from stakeholders.

Working within the confines of the statute, CMS is currently engaged in efforts to examine our existing APMs and see where alterations can be made to the design of those initiatives that both satisfy obligations to current model participants and allow participants to qualify for the Advanced APM incentive payments. The proposed rule is only the first step of an iterative implementation process, and CMS looks forward to comments and feedback on the proposed rule.

From Representative Tom Price of Georgia:

Serious Challenges with Timing of Reporting

1. **The proposed MACRA rule states that physicians would only receive performance feedback on quality and resource use on an annual basis. Physicians have asked for more timely access to data. What steps has CMS taken to improve its systems so that physicians can get data on a timely basis?**

2. **Congress told CMS in MACRA (Social Security Act Sec. 1848(q)(4)) that the MIPS performance period "shall begin and end prior to the beginning of [the payment year]** *and be as close as possible* **to such year" (emphasis added). In your proposed rule CMS**

proposes that the performance period begin on Jan. 1, 2017, fully two years before the first day of payment adjustments under MIPS -- which is on Jan. 1, 2019. We now have experience with a 2-year delay between performance and payment in the other value-based programs (MU, PQRS, and VBM), and we know that physicians find a 2-year gap between performance and payment to be very frustrating. How can CMS reduce the gap between performance and payment, in accordance with Congress's intent?

Answer 1 & 2: CMS works continuously to gather feedback from physicians, and we have heard that physicians generally want a one year performance period and an additional three to four months to finish reporting. Physicians expressed concerns that a shorter performance period could potentially mean less mature claims, a less accurate portrayal of physician activities, or less time for physicians to review data. In order to allow clinicians a full year performance period, adequate reporting time for clinicians, and adequate time for CMS to analyze the data before implementing the MIPS payment adjustment as mandated in the year 2019, CMS has proposed to establish calendar year 2017 as the first performance period. However, the majority of clinicians would not need to begin submitting data until 2018, and they would be given several months to fulfill these requirements.

CMS understands that being prepared for the changes brought by MIPS implementation is critically important for clinicians. When it comes to reporting their performance, clinicians have many options under the proposed rule. For those already participating in the Physician Quality Reporting System (PQRS), they are able to continue to report using one of the methods to which they are accustomed, such as through data registries or directly from their EHR. Clinicians who are new to reporting can also take advantage of these options to report their data.
CMS is committed to working with clinicians, medical societies and other stakeholders on resources to help clinicians pick the approach that will best meet their individual needs. For example, clinicians using registries for reporting may be able to work with those registries to receive more frequent feedback on their performance. Congress also included resources for technical assistance to help practices meet these challenges. The proposed rule is only the first step of an iterative implementation process and CMS looks forward to comments and feedback on the proposed rule, including the proposed performance period.

Impact on Small/Solo Practices

3 . Under the proposed MACRA rule, physician practices with Medicare charges of less than or equal to $10,000 and 100 or fewer Part B-enrolled Medicare beneficiaries under their care are exempt from MIPS. Would CMS consider raising the threshold to ensure that small and solo practices are not unfairly targeted for payment cuts?

Answer: In our proposed rule, we define MIPS eligible clinicians or groups who do not exceed the low-volume threshold as an individual MIPS eligible clinician or group who, during the performance period, have Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Part B-enrolled Medicare beneficiaries. We believe this strategy is value-oriented as it retains as MIPS eligible clinicians those clinicians who are treating relatively few

beneficiaries, but engage in resource-intensive specialties, or those treating many beneficiaries with relatively low-priced services. By requiring both criteria be met, we can meaningfully measure the performance and drive quality improvement across the broadest range of MIPS eligible clinician types and specialties. Conversely, it excludes MIPS eligible clinicians who do not have a substantial quantity of interactions with Medicare beneficiaries or furnish high cost services. We plan to monitor the proposed requirement and anticipate that the specific thresholds will evolve over time. The proposed rule is only the first step of an iterative implementation process and CMS looks forward to comments and feedback on the proposed rule, including on how we could potentially differently define these thresholds in a way that accomplishes our goals.

4. **In 2019, when the payment adjustments under MIPS are first implemented, CMS estimates that 87 percent of solo practitioners will face penalties totaling $300 million. Practices with two to nine physicians will face penalties of $279 million. What is CMS doing to prevent further consolidation within healthcare as a result of this rule. Additionally, how does CMS plan to address the problem of small and solo practices being disproportionately penalized in the final rule?**

Answer: Small practices (typically defined as 15 or fewer clinicians) and practices in rural or health professions shortage areas play a vital role in the care of Medicare patients with diverse needs. CMS is sensitive to the unique challenges that small practices face in different types of communities, and the policies proposed under the Quality Payment Program would accommodate various practice sizes and configurations. In addition, CMS is sensitive to the concerns expressed in response to the proposed rule's regulatory impact analysis, which was perceived to show that the Quality Payment Program would negatively impact small practices. This regulatory impact analysis is based on 2014 data when many small and solo practice physicians did not report performance on PQRS measures. It also does not reflect the policies in the proposed rule that are intended to provide additional flexibility to various practice sizes and configurations. CMS is committed to a continued dialogue regarding the obstacles and challenges these practices encounter, both during the rulemaking period and throughout the implementation of the Quality Payment Program.

<u>APMs for Specialties</u>

5. **The performance period beginning in 2017 means that very few specialists will have access to APMs prior to the expiration of the APM incentives. Clinicians will be eligible for a 5% payment bonus under APMs from 2019-2024. Does CMS have the resources to approve/implement new specialty APM proposals in a timeframe to meet the deadline for the incentive period?**

Answer: CMS appreciates that many clinicians, including specialists, are eager for opportunities to participate in Advanced APMs. Working within the confines of the statute, CMS is currently engaged in efforts to examine our existing APMs and see where alterations can be made to the design of those initiatives that both satisfy obligations to current model participants and allow participants to qualify for the Advanced APM bonus payments. For example, in our proposal, we

requested comments on how we might change the design of the Comprehensive Care for Joint Replacement (CJR) model through future rulemaking to make it an Advanced APM, and on how to include eligible clinicians in CJR as qualifying participants of Advanced APMs.

We also note that specialists currently participate in and can apply to join other APMs proposed to be Advanced APMs that are not specialty-specific, including Tracks 2 and 3 of the Medicare Shared Savings Program, Comprehensive End-Stage Renal Disease Care Initiative (Large Dialysis Organization arrangement), and the Next Generation Accountable Care Organization Model.

6. **If CMS doesn't have the resources to consider physician-focused payment model (PFPM) from the PTAC, then why is CMS expending additional resources through CMMI in developing their own advanced APMs?**

7. **What plans does CMS have to utilize CMMI in the development of Advanced APMs and will physicians or the PTAC be consulted prior to the rollout of new CMMI advanced APMs.**

Answer 6 & 7: CMS agrees that it is important for physicians to be able to participate in Advanced APMs. To help spur innovation for models that meet the needs of the physician community, MACRA established a new independent advisory committee, the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The PTAC will meet at least a quarterly to review physician-focused payment models submitted by individuals and stakeholder entities and prepare comments and recommendations on proposals that are received, explaining whether models meet criteria for physician-focused payment models. The eleven members of the PTAC, who were appointed by the Comptroller General, are experts in physician-focused payment models and related delivery of care, including researchers, practicing physicians, and other stakeholders. CMS looks forward to receiving these critical recommendations for new physician-focused payment models. We encourage physician specialists and other stakeholders to engage with the PTAC to suggest well designed, robust models. We are committed to working closely with the PTAC and are looking forward to reviewing their recommendations.

Outreach and collaboration are a critical part of our work to expand participation in Advanced APMs, and CMS looks forward to the opportunity to apply the experience of the Innovation Center during our review of recommended PTAC models.

In addition, CMS's Center for Medicare and Medicaid Innovation (Innovation Center) is actively seeking ideas from the public, including specialty physicians and societies, on how care can be delivered and paid for in ways that will lower the total costs while improving quality. Ideas may be submitted by visiting our website[1] https://innovation.cms.gov/Share-Your-Ideas/index.html.

8. **Going forward, what plans does CMS have to work with and, where appropriate, provide assistance to physicians to ensure that all physicians will have every**

[1] https://innovation.cms.gov/Share-Your-Ideas/index.html

opportunity to create alternative payment models which fit their unique specialty, practices and patients?

Answer: CMS looks forward to receiving recommendations from the PTAC for new physician-focused payment models. In the proposed rule, we propose criteria for the PTAC to use in making recommendations for physician-focused payment models. We also published in the proposed rule a list of factors CMS typically uses in the selection of models for testing (https://innovation.cms.gov/Files/x/rfi-websitepreamble.pdf). In order to facilitate and potentially expedite the consideration of models for testing by CMS following PTAC review and recommendation, we also identified "supplemental information elements" stakeholders may include in their physician-focused payment models proposals to assist with model review.

In addition, CMS's Center for Medicare and Medicaid Innovation (Innovation Center) is actively seeking ideas from the public, including specialty physicians and societies, on how care can be delivered and paid for in ways that will lower the total costs while improving quality. Ideas may be submitted by visiting our website: https://innovation.cms.gov/Share-Your-Ideas/index.html.

We know that physicians and other clinicians may need assistance in transitioning to the MIPS, and we want to make sure that they have the tools they need to succeed in a redesigned system. Congress provided funding in MACRA for technical assistance to small practices, rural practices, and practices in medically underserved health professional shortage areas. This will be accomplished through national, regional and local activities such as webinars, national associations, Open Door Forums and continuing medical education.

In addition, CMS awarded $685 million to 39 national and regional health care networks and supporting organizations to provide technical assistance support to help equip more than an estimated 140,000 clinicians with the tools and support needed to improve quality of care, increase patients' access to information, and spend dollars more wisely through the Transforming Clinical Practice Initiative, which is designed to help clinicians achieve large-scale health transformation.

MIPS Generally

9. **A Washington Post article released last week (dated May 3, 2016) stated that medical errors in healthcare facilities are now the third leading cause of death in the United States, claiming more lives than respiratory disease, accidents, stroke, and Alzheimer's. Is it possible that excessive quality reporting may have an adverse effect on patient care**

Answer: We recognize the need to address medical errors in healthcare facilities. We have targeted efforts at patient safety in recent years, with successful initiatives to reduce healthcare–associated infections and hospital acquired conditions. These have included the Partnership for Patients (PfP) initiative, as well as work of the Quality Improvement Organizations. The work of the Hospital Engagement Networks in the PfP, for example, has targeted a specific set of hospital-acquired conditions through public-private partnerships, the spread of best practices, and

systematic quality improvement work. We are already seeing national trends in health care improvements that are promising and likely a combined result of our efforts:

- Interim estimates for 2014 show a sustained 17 percent decline in hospital-acquired conditions, such as pressure ulcers, infections, and avoidable traumas, since 2010, representing over 87,000 lives saved and nearly $20 billion in health care cost savings.[2]
- Between April 2010 and May 2015, an estimated 565,000 readmissions were prevented across all conditions, compared to the readmission rate in the year prior to the passage of the Affordable Care Act (April 2009 to March 2010). That is 565,000 times that a patient didn't have to experience an extra hospital stay.[3]

Quality reporting is critical both to gauge progress and to incentivize improvement. Reporting should not be excessive or burdensome, but should allow clinicians and providers to focus on areas that are directly relevant to treatment of their patients and provide them valuable information. We recognize the need to continue to prioritize the area of patient safety in the coming years. The recently released draft Measure Development Plan includes the area of patient safety as among those prioritized measure gap areas identified by stakeholders. In addition, in the proposed rule, patient safety measures are defined as high priority measures under MIPS.

CMS has worked with America's Health Insurance Plans, commercial payers, and a broad collaborative of health care system participants (known as the Core Quality Measures Collaborative) to establish core measures for physician quality programs. The goal of this effort is to establish broadly agreed upon core measure sets that could be harmonized across both commercial and government payers, which will add focus to quality improvement efforts, reduce the reporting burden of quality measures, and offer consumers actionable information for decision-making.

We believe that the proposed streamlined and focused reporting under the Quality Payment Program, as well as the future development of patient safety evidence-based measures, will assist with and add to our efforts to continue to make progress in this challenging but critically important area.

10. Under MIPS, doctors will receive payment adjustments based on the scores they achieve relative to other providers. To me, this is a lot like the situation where a professor tells a class that he will only give 5 students "As", regardless of whether or not you score above 90%. Is this the fairest way to incentivize doctors to accept this program, particularly when physicians are unable to fully control their ability to avoid a penalty?

Answer: The statute requires that payment adjustment factors be applied on a linear sliding scale for both upward and downward adjustments. The statute also includes a requirement for budget neutrality, under which, subject to certain limited exceptions, the estimated increase in the aggregate allowed charges resulting from the application of positive MIPS adjustment factors is

[2] http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2014.html
[3] http://www.hhs.gov/blog/2016/02/24/reducing-avoidable-hospital-readmissions.html

equal to the estimated decrease in the aggregate allowed charges resulting from the application of negative MIPS adjustment factors.

While aligning with these statutory provisions, we propose a scoring methodology that allows for accountability and alignment across the performance categories and minimizes burden on MIPS eligible clinicians. Further, we propose a scoring methodology that is meaningful, understandable and flexible for all MIPS eligible clinicians. Our proposed methodology allows for multiple pathways to success with flexibility for the variety of practice types and reporting options. First, we have proposed multiple ways that MIPS eligible clinicians may submit data to MIPS for the quality performance category. Second, we generally do not propose ''all-or-nothing'' reporting requirements for MIPS. Third, bonus points would be available for reporting high priority measures and electronic reporting of quality data. Under our proposed rule, clinicians who are subject to MIPS payment adjustments have opportunities to succeed. CMS intends to publicly announce the benchmarks for this program in advance so clinicians have time to prepare their practices. The proposed rule is only the first step of an iterative implementation process and CMS looks forward to comments and feedback on the proposed rule, including the proposed scoring methodology.

The New Meaningful Use: Advancing Care Information

11. The ACI program takes the Meaningful Use Stage 3 measures and simply establishes new mechanisms for calculating a physician's successful participation. This is not a major overhaul of the program and it will not encourage software vendors to improve the usability and interoperability their systems. Consequently, for the foreseeable future, physicians are going to spend more time checking boxes than delivering patient care. How does the agency intend to make good on your CMS's promise to overhauling this dysfunctional program?

12. The ACI program makes up 25% of the total MIPS score; however, despite promises of fixing the burdensome MU program, it appears that ACI is even more complicated than MU. For example, I understand that if providers don't satisfy all of the requirements for the base score, they will receive a zero, which will cause them to receive payment cuts under MIPS. While the performance score does offer some flexibility, there is room to make the program more workable. Looking ahead, what steps is CMS taking to ensure that there will be more flexibility within ACI, opposed to the current EHR meaningful use efforts?

Answer 11 & 12: As we considered all the input we received from thousands of stakeholders across the country during development of the proposed rule, it created a clear blueprint for how we proposed to go forward to replace Meaningful Use for Medicare providers with a more flexible, outcome-oriented and less burdensome proposal. The implementation of the advancing care information performance category is an important opportunity to increase clinician and patient engagement, improve the use of health IT to achieve better patient outcomes, and continue to meet the vision of enhancing the use of certified EHR technology.

In our proposed rule, we address these critical issues by proposing to eliminate measurements that are overly burdensome or redundant, allowing technology to focus on interoperability and be flexible enough to fit into the clinical workflow. We proposed a more flexible evaluation and removed some threshold requirements, lowering the burden on providers. We also proposed that clinicians could = report as a group, as well as multiple paths available to clinicians to achieve the maximum score for this category. There would be an all-time low of eleven measures, down from eighteen measures in the current EHR Incentive program. Compared to the existing Medicare EHR Incentive program, the new approach increases flexibility, focuses on interoperability, and reduces burden. We are dedicated to ensuring technology is a meaningful tool that provides real value for clinicians.

These improvements increase program flexibility and support the advancement of innovative technology that can meet the needs of providers and the patients they serve. For example, we are requiring open application programming interfaces in newly certified technology so the clinician desktop is opened up to allow apps, analytic tools, and medical devices to plug and play. We urge developers to take advantage of the flexibility to design around the everyday needs of the users, rather than designing to a one size fits all approach. Already, developers that provide over 90 percent of electronic health records used by U.S. hospitals have made public commitments to make it easier for individuals to access their own data; not block information; and speak the same language.[4] The provisions in the proposed rule are a critical step in support of these efforts to achieve true interoperability of health information. However, the proposed rule is only the first step of an iterative implementation process and CMS looks forward to comments and feedback on the proposed rule, including the proposed approach to Advancing Care Information.

13. **The 8 performance measures under ACI require extremely challenging patient engagement measures, which physicians have continually expressed concerns about their practicality. For example, the secure messaging measure requires that physicians either send a secure electronic message or reply to a secure electronic message to 100% of their patients to achieve 100% of the measure rather than the 5% threshold that was originally required in Stage 2 of Meaningful Use. Given that the lower threshold under Stage 2 was too high for most physicians to achieve, what was the rationale for setting the 100% threshold in ACI? If most physicians were unable to attest to a much lower threshold under Stage 2, how will physicians be able to meet the new required 100% threshold?**

Answer: CMS recognizes the potential benefits and challenges to adopting and implementing new applications of certified health information technology – including secure messaging. We have received feedback from physicians and other stakeholders that some patients are unable or reluctant to send secure messages due to data breach fears, lack of internet familiarity, and overall lack of access. As a result, CMS modified the Secure Messaging measure in the Medicare and Medicaid Programs: Electronic Health Record Incentive Program-Stage 3 and Modifications to Meaningful Use in 2015 Through 2017 Final Rule. The rule changed the Secure Messaging measure threshold for the Medicare EHR Incentive Program in 2015 to enable the capability to

[4] http://www.hhs.gov/about/news/2016/02/29/hhs-announces-major-commitments-healthcare-industry-make-electronic-health-records-work-better.html

send or receive a secure electronic message. For 2016, the rule modified the threshold so that a secure message had to be sent to *at least one* patient. Said differently, eligible professionals must send a secure message to one patient to achieve the Secure Messaging measure in 2016.

Furthermore, CMS has ***not*** proposed to set a threshold of 100 percent for the Secure Messaging measure under MIPS. Rather, we have proposed that eligible clinicians will get full credit toward the "base score" of the Advancing Care Information (ACI) performance category as long as they report a numerator *of at least one* for the Secure Messaging measure as well as other measures included in the base score. More specifically, eligible clinicians that report that they have sent a secure message to at least one patient during the performance period would meet the requirements of the Secure Messaging measure and receive credit toward the ACI base score. The base score would make up 50 percent of the overall ACI performance category score.

Under the performance score – which would make up the other 50 percent of the overall ACI performance category – eligible clinicians would be able to earn additional points for performance on the objectives and eight corresponding measures for Patient Electronic Access, Coordination of Care through Patient Engagement, and Health Information Exchange. Importantly, under the proposed rule, eligible clinicians would have flexibility to focus on the measures that are right for their patients and their practice. Even though the Secure Electronic Messaging measure is one of the measures that would be included in the performance score, eligible clinicians may choose to focus on the other measures and still receive full credit for the ACI performance category.

Appeals

14. The process to appeal one's MIPS score consists of no hearing or evidence submission process, and any decision made on appeal is final and has no additional process for further review or appeal. Can you please explain the rationale for the development of such an appeals process under MIPS?

15. Without a hearing or evidence submission process, how will CMS be able to provide assurance to a physician that his or her appeal has been fairly considered?

Answer 14 & 15: MACRA requires the establishment of a process under which a MIPS eligible clinician may seek an informal review of the calculation of the MIPS adjustment factor (or factors) applicable to such MIPS eligible clinician for a year. The statute does not require a formal appeals process and includes limits on administrative and judicial review on certain items, including the methodology used to determine the amount of the MIPS adjustment factor and the determination of the amount.

We recognize that a principled approach to requesting and conducting a targeted review is required under the MACRA in order to minimize burdens on MIPS eligible clinicians and ensure transparency under MIPS. We also believe it is important to retain the flexibility to modify MIPS eligible clinicians' composite performance score (CPS) or payment adjustment based on the

results of targeted review. This will lend confidence to the determination of the CPS and payment adjustments, as well as providing finality for the MIPS eligible clinician after the targeted review is completed. It will also minimize the need for claims reprocessing. In our proposed rule, we propose an approach that outlines the factors that we would use to determine if a targeted review may be conducted. In keeping with the statutory direction that this process be "informal," we have attempted to minimize the associated burden on the MIPS eligible clinician to the extent possible.

If a request for targeted review is approved, the outcome of such review may vary. For example, we may determine that the clinician should have been excluded from MIPS, redistribute the weights of certain performance categories within the CPS (for example, if a performance category should have been weighted at zero), or recalculate a performance category score in accordance with the scoring methodology for the affected category, if technically feasible. The proposed rule is only the first step of an iterative implementation process and CMS looks forward to comments and feedback on the proposed rule, including the proposed implementation of an informal review process.

Site Neutrality

16. Mr. Slavitt, do you believe that the proposed MACRA regulation is pushing physicians to move from private practice into a model where they are employed? What protections are included in the regulations that would protect the private practice physician?

Answer: A key focus in our efforts has been to reduce burden by keeping the proposed Quality Payment Program as simple as possible and providing clinicians with flexibility in meeting requirements.

We are committed to working with private practices to make sure they have the tools they need during this transition, and Congress provided funding in MACRA for technical assistance to small practices, rural practices, and practices in medically underserved health professional shortage areas. We are also actively seeking feedback on our proposals and on ways we could better serve the needs of small practices.

CJR: CMS Failed to Include CJR and BPCI in MACRA's Approved APMs

17. Many physicians have already invested substantial financial and structural resources in answering CMS's call to shift to existing CMMI APM models, which they have now learned may not qualify as Advanced APMs under MACRA. Why did CMS propose MACRA APM standards that many CMMI APM models do not meet?

Answer: We recognize the substantial time and money commitments in which APM participants invest in order to become successful participants. The statute creates a high bar for APMs that could be considered Advanced APMs.

To qualify as an Advanced APM, we proposed that an APM must meet three criteria specified in the statute. The APM must:

- Require participants to use certified EHR technology
- Provide payment for covered professional services based on quality measures comparable to those in the quality performance category under MIPS
- Require that participating APM entities bear risk for monetary losses of more than a nominal amount or be a Medical Home Model expanded under CMMI authority.

Working within the confines of the statute, CMS is currently engaged in efforts to examine our existing APMs and see where alterations can be made to the design of those initiatives that both satisfy obligations to current model participants and allow participants to qualify for the Advanced APM incentive payments. The proposed rule is only the first step of an iterative implementation process, and CMS looks forward to comments and feedback on the proposed rule.

18. How would MIPS incentives and penalties work for physicians participating in a mandatory bundled payment model like CJR?

Answer: We want to make sure that in addition to encouraging clinicians to improve quality of care by participating in APMs that best fit their practice and patient needs, clinicians are not subject to duplicative, overly burdensome reporting requirements. As we move forward with MACRA implementation, we will continue to gather and incorporate feedback from stakeholders as we promote additional physician-focused APMs. In addition, in our proposed rule, we specifically sought feedback on how we might change the design of the Comprehensive Care for Joint Replacement (CJR) model through future rulemaking to make it an Advanced APM, and on how to include eligible clinicians in CJR as qualifying participants of Advanced APMs. We look forward to receiving and reviewing comments from stakeholders.

19. How will CMS ensure that CJR/APM participants who specialize in taking on the toughest cases are not penalized?

Answer: CJR uses a specific pricing methodology for hip fracture patients due to the significantly higher spending associated with these more complex cases. CJR uses a simple risk stratification methodology to set different target prices for patients with hip fractures within each Medicare Severity-Diagnosis Related Group. We believe that this risk stratification policy addresses concerns that beneficiaries with serious conditions, acute diseases, and chronic conditions are likely to need more costly care throughout the CJR model episode because these beneficiaries are those most likely to be present in the population receiving lower extremity joint replacement procedures emergently due to a hip fracture.

20. Do CMMI and CMS plan to work together to tweak these CMMI APMs, such as CJR and BPCI, so that they will qualify as an advanced APM under MACRA?

Answer: While the Bundled Payments for Care Improvement (BPCI) Models 2, 3, and 4 would meet the proposed financial risk criterion for Advanced APMs, they do not require participants to use certified EHR electronic health record technology or incorporate quality measure results as a factor when determining payment to participants, as required by statutory criteria. In addition, in our proposed rule, we specifically sought feedback on how we might change the design of the CJR model through future rulemaking to make it an Advanced APM, and on how to include eligible clinicians in CJR as qualifying participants of Advanced APMs. We look forward to receiving and reviewing comments from stakeholders.

Working within the confines of the statute, CMS is currently engaged in efforts to examine existing APMs established under the Innovation Center and see where refinements can be made that both satisfy obligations to current model participants and allow eligible clinician participants to qualify for the APM incentive payments.

21. Why would physicians stay in APMs that are not qualified under MACRA? Is CMS concerned that physicians participating in some of these non-qualified CMMI APMs will cease participation in these models?

Answer: Participants of certain APMs that are not considered Advanced do have advantages in the proposed MIPS scoring process For example, under the proposed rule, clinicians who participate in Advanced APMs but do not meet the law's criteria for sufficient participation in Advanced APMs, and those who participate in certain non-Advanced APMs, would be exempt from the cost category in MIPS, would be able to use their APM quality reporting for the MIPS quality category, and would receive credit toward their score in the Clinical Practice Improvement Activities category. We want to make sure that in addition to encouraging clinicians to improve quality of care by participating in APMs that best fit their practice and patient needs, clinicians are not subject to duplicate, overly burdensome reporting requirements. The proposed rule is only the first step of an iterative implementation process and CMS looks forward to comments and feedback on the proposed rule.

Private Practice Physical Therapists

22. While physical therapists (PTs) are not initially included in MIPS, the Secretary may add them or other excluded specialties to MIPS beginning in 2021. However, at this time, the factors by which additional eligible professionals will be included are unknown. Does CMS plan to include in its rulemaking this year a clear disclosure of its criteria to determine the inclusion of non-physician professionals such as physical and occupational therapists in MIPS beginning in 2021?

Answer: Physical therapists and other non-physician clinicians who are not subject to the initial MIPS payment adjustments are important parts of the health care delivery system. Currently, many of these professionals report to CMS under the Physician Quality Reporting System (PQRS), and they would have the option of continuing to report quality measures to MIPS. For individual clinicians and groups that are not initially considered MIPS eligible clinicians, such as physical therapists, but elect to report to MIPS, we would calculate all data available and issue

them a feedback report. As you noted, the statute provides the Secretary with the flexibility to specify additional eligible clinicians in the third and subsequent years of MIPS and we intend to consider using this authority to expand the definition of MIPS eligible clinicians through rulemaking in future years.

Timeline

23. Congress intended to offer physicians a period of relief spanning from 2015-2018 before making the changes necessary to implement MACRA beginning in 2019. However, under the proposed regulation, the first reporting period begins January 1, 2017, less than 7 months from now. Can you please explain why CMS moved the timeline forward to 2017 instead of 2019 as the law states?

Answer:
CMS works continuously to gather feedback from physicians, and we have heard that physicians generally want a one year performance period and an additional three to four months to finish reporting. Physicians expressed concerns that a shorter performance period could potentially mean less mature claims, a less accurate portrayal of physician activities, or less time for physicians to review data. In order to allow clinicians a full year performance period, adequate reporting time for clinicians, and adequate time for CMS to analyze the data before implementing the MIPS payment adjustment as mandated in the year 2019, CMS has proposed to establish calendar year 2017 as the first performance period. However, the majority of clinicians would not need to begin submitting data until 2018, and they would be given several months to fulfill these requirements.

CMS understands that being prepared for the changes brought by MIPS implementation is critically important for clinicians. When it comes to reporting their performance, clinicians have many options under the proposed rule. For those already participating in the PQRS, they are be able to continue to report using one of the methods to which they are accustomed, such as through data registries or directly from their EHR. Clinicians who are new to reporting can also take advantage of these options to report their data.

CMS is committed to working with clinicians, medical societies and other stakeholders on resources to help clinicians pick the approach that will best meet their individual needs. For example, clinicians using registries for reporting may be able to work with those registries to receive more frequent feedback on their performance. Congress also included resources for technical assistance to help certain practices meet these challenges. The proposed rule is only the first step of an iterative implementation process and CMS looks forward to comments and feedback on the proposed rule, including the proposed performance period.

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